FINAL AWARD ALLOWING COMPENSATION
(Modifying Award and Decision of Administrative Law Judge)

Employee: Danny L. Harris Injury No.: 09-018179

Employer: Ralls County

Insurer: Missouri Association of Counties

This workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. We have reviewed the evidence, read the parties' briefs, and considered the whole record. Pursuant to § 286.090 RSMo, we modify the award and decision of the administrative law judge. We adopt the findings, conclusions, decision, and award of the administrative law judge to the extent that they are not inconsistent with the findings, conclusions, decision, and modifications set forth below.

Preliminaries
The parties asked the administrative law judge to determine the following issues: (1) whether employee[1] sustained injury arising out of and in the course of his employment; (2) whether and to what extent, any injury sustained was medically causally related to the accident; (3) the nature and extent of any permanent disability; and (4) the need for future medical treatment.

The administrative law judge determined as follows: (1) employee sustained a work-related accident on March 9, 2009, that arose out of and in the course of his employment; (2) employee sustained low back injury which was medically causally related to employee's work accident; (3) employee is permanently and totally disabled; and (4) employer is responsible for future medical treatment to treat and relieve the effects of the injury.

Employer filed a timely application for review with the Commission alleging the administrative law judge erred in: (1) failing to identify a medical condition arising from a workplace accident; (2) finding the accident was the prevailing factor in causing employee's low back symptoms; (3) finding that the accident was the prevailing factor resulting in the need for treatment of low back symptoms; (4) finding that the accident was the prevailing factor in causing psychological symptoms of depression; (5) finding that employee was permanently and totally disabled; and (6) finding that employer was responsible for future medical treatment.

Additionally, in Respondent's brief before the Commission (page 34), employee first alleged that employer is liable for attorney's fees under §§ 287.203 and 287.560 RSMo. The administrative law judge ruled (at page 2 of the Award), that employee's compensation award shall be subject to a lien in the amount of 25% of all payments for necessary legal services rendered by employee's attorneys, Mark Haywood and Noel Sevastianos. We do not disturb that ruling. However, we see no basis to find the employer liable for those fees for the assessment of the whole cost of the proceedings for defense or prosecution without reasonable ground.

For the reasons stated below, we modify the award and decision of the administrative law judge referable to the issues of: (1) medical causation; (2) nature and extent of disability; and (3) future medical benefits. We substitute our own Findings of Fact and Conclusions of Law.

[1] We note that the record and the pleadings in this matter refer throughout to claimant. Because of the relevant definitions under § 287.020, we generally refer to the injured worker as "employee" and to anyone else pursuing a claim on behalf of the employee, as "claimant." We use the designation of "employee" throughout this award.

Findings of Fact

Danny Harris (employee) worked for the County of Ralls performing road work beginning July 2007, including driving a dump truck. On March 9, 2009, employee and a co-worker were told to change a tire on a backhoe. In order to do so, they commenced by breaking the seal on the tire away from the rim. After completing one side of the tire they needed to flip it over to get to the other side.[2] This required some lifting motion while employee was in a stooped position. As he helped lift and flip the tire, he felt a sensation in his low back which he described as "like you were squishing a jelly donut," and "it was like someone was stabbing me in the back with a knife and it went down my legs, into my feet." *Transcript,* page 31. By the next day, he realized he may need medical attention and requested his employer allow him to see a doctor. After working a few hours, he went to the emergency room. Employee was about 30 years old at the time of the incident.

He was under conservative treatment from that day until June 17, 2009, during which time he had several imaging and diagnostic tests (MRI, EMG, X-ray), physical therapy and steroid shots. Dr. Russell Cantrell, a physiatrist at Orthopedic and Sports Medicine Inc., released him to return to limited duty, with restrictions on lifting up to 10 pounds, and driving only a personal vehicle, as opposed to a dump truck. He underwent a functional capacity evaluation on June 29, 2009. That evaluation found him capable of working safely in the heavy work demand level, but that his documented performance did not meet the employer-reported job demands. *Transcript,* page 234. At the evaluation session, employee was capable of lifting up to 55 pounds from floor to waist, 75 pounds from waist to shoulder and from shoulder to overhead, and could bilaterally carry up to 65 pounds and unilaterally carry up to 70 pounds, (either arm). Dr. Cantrell saw him again after the evaluation, on June 29, 2009, and July 21, 2009. A CT scan and myelogram were ordered because employee continued to complain of pain in July 2009.[3] As of August 31, 2009, Dr. Cantrell found he could return to duty with permanent restrictions of no lifting over 50 pounds, and alternating sitting and standing every hour. The doctor approved driving the dump truck not to exceed one hour of sitting time. Employee was found to be at maximum medical improvement (MMI) at this time, per stipulation of the parties.

Employee indicates that when he returned to work, he used leave to account for some of his time, such that he did not consider himself to be working a full time schedule. Employee continued working until March 25, 2011, when he indicates he was laid off. Employee stopped working at that time for reasons that are not clear. On March 29, 2011, employee saw his primary care physician, Dr. Hevel, complaining of back pain, and his doctor noted possible depression. The doctor suggested he stay off work for a while at that point. Employee was undergoing marital and family issues beginning in early-mid 2011, which resulted in a separation from his wife and children, and ultimately, employee was jailed[4] in August 2011 until August 2013. Employee experienced some episodes of depression during this time and consulted with a psychiatrist, Dr. Jonathan Colen and a therapist, Sean Meyer until July 2011. His employment was not terminated by the employer until December 2011.

At the hearing in November 2017, employee indicated he was not depressed at that time and that his physical pain had gotten worse.[5] He indicated he was using a cane for two-three years because he would fall down for no reason. No doctor diagnosed any issues with his gait or recommended the need for any assisted walking device. Employee had knee surgery in 2006

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[2] The only evidence of the weight of the object is from employee's testimony, when asked what he believed was the approximate weight of the tire. His response was about 350 pounds.
[3] Repeat MRI and EMG studies were done in 2010, because of employee's continuing pain complaints.
[4] There is no evidence in the record that employee was convicted of any crime. Employee reports he was acquitted of all charges.
[5] Employer's psychiatric expert, Dr. Edwin Wolfgram opined in February 2015, that employee's depression was not work-related, but more likely from other family and social behavior factors. He noted concern that employee was addicted to pain medication and it was advisable to treat for opiate addiction in the future.

or 2007. Employee indicated at the hearing that he goes to the emergency room because of pain about twenty times a year. There are no medical records documenting this.

Employer provided medical care for employee through authorized physicians, Dr. James Coyle, a neurosurgeon (Midwest Spine Surgeons), and Dr. Russell Cantrell. The last documented visits with these treating doctors were in fall of 2010, but Dr. Cantrell, continued monitoring his medications.[6] During the course of treatment, employee underwent the following objective medical tests.

- An x-ray within days of March 9, 2009, showing spondylolysis. *Transcript,* page 168. (Dr. Coyle's office)
- An MRI on March 16, 2009, identified degenerative discs L4-5, L5-S1, central disc prolapse L4-5, spondylolisthesis at L5-S1, with a very small disc protrusion, *Transcript,* page 163, (Dr. Coyle) and 168 (Nurse practitioner- Coyle's office). Dr. Cantrell opined degenerative conditions. *Transcript,* pages 174, 178.
- An EMG on June 6, 2009, with no abnormal findings, no lumbar radiculopathy or lumbosacral plexopathy. *Transcript,* pages 176, 179 (Dr. Cantrell, referring to Dr. Boris Khariton).
- A July 2009, myelogram and CT scan showed mild spondylolisthesis of L-5 on S-1, degenerative disc changes and small disc protrusions at L3-4. *Transcript,* pages 175, 179 (Dr. Cantrell)
- A second EMG was done in September 2010, generally, was within normal limits, but showed some abnormalities, consistent with bilateral S-1 radiculopathy, but not at the L4 or L5 level. *Transcript,* pages 175, 177, 183 (Dr. Cantrell).
- Another MRI performed in October 2010, was notable for degenerative discs, mild dessication at L4 and L5 with annular tears at each level, and spondylolisthesis at L5-S1. An abnormally small spinal canal, a congenital condition was noted. There was mild disc pathology but no focal compressive pathology. *Transcript,* pages 153,156,157 (Dr. David Niebruegge, Dr. Coyle).

This series of objective testing documents the authorized treating doctors' attempts to identify and diagnose the conditions underlying employee's reported symptoms of radiculopathy into the lower extremities and the causes of his low back pain. It is notable that while some variations appear in the interpretation of the test results, any radiculopathy identified in objective findings does not appear until long after the March 9, 2009 workplace event. One consistent observation is degenerative processes in the lumbar region.

The doctors we find most persuasive, Dr. Robert Bernardi, Dr. Coyle, and Dr. Cantrell conclude that the majority of employee's symptoms are from degenerative and congenital conditions, objectively identified through testing. These doctors also acknowledge that some of the symptoms asserted by employee can result from acute injury and that a spondylolisthesis (disc slippage) can be caused by injury.

Ultimately, Dr. Cantrell, opined on June 8, 2011, that there is no objective evidence to support employee's subjective complaints of radiating pain into both lower extremities. He noted that previous diagnostic studies revealed degenerative changes in his lumbar spine. *Transcript,* pages 178-179. He further noted that electrodiagnostic studies failed to show any evidence of radiculopathy, "and a myelogram and CT scan revealed evidence of spondylolisthesis of L5 on S1 that was of a mild degree, along with bilateral spondylolysis." *Id.* Dr. Cantrell's opinion in his final report was that the medications employee continues to use are more likely than not the

[6] Employee also saw other primary care physicians, including Dr. Hevel, on occasion thereafter.

result of degenerative processes. *Transcript,* page 177.[7] Employee had been prescribed Tramadol and Prevacid for stomach upset associated with the medication. Dr. Coyle prescribed ibuprofen in October 2010. Dr. Cantrell noted that the additional abnormal developments shown in subsequent testing (which were not present in earlier tests), are more consistent with a continued degenerative process. *Transcript,* page 177. He also rated employee's disability at 8%, permanent partial disability of the person as a whole relative to his lumbar and lower extremity complaints, only half of which he attributed to the work injury.

Dr. Coyle, the authorized surgeon that employee consulted with, reviewed the initial MRI. In May 2009, he noted a central disc prolapse at L4-5 and isthmic spondylolisthesis at L5-S1, with a very small central disc protrusion. *Transcript,* page 163. According to Dr. Coyle, a second EMG in Fall 2010, showed S-1 radiculopathy. Following Dr. Coyle's reading of an updated MRI on October 27, 2010, his final diagnosis was degenerative discs in the lumbar region, isthmic spondylolisthesis at L5-S-1 and an annular tear at L4-5, but nothing acute was identified. *Transcript,* page 153. Dr. Coyle did not recommend any spinal surgery and none was performed. Dr. Coyle does not make a finding that the accident was the prevailing factor in any of the resulting medical conditions.

The employer's independent medical examination (IME) expert Dr. Robert Bernardi, a board certified neurosurgeon, examined employee in November 2015. His opinion is consistent with the objective findings documented throughout the medical records of Dr. James Coyle, Dr. Russell Cantrell, Dr. David Niebruegge, and Dr. Boris Khariton. Dr. Bernardi identifies a "lumbar sprain/strain as a result of (employee's) 03/09/2009 work accident." *Transcript,* page 455. Such an injury, he explained would have been expected to resolve within 4-6 weeks. *Transcript,* page 333. He explained that "degenerative disc disease is almost a hundred percent governed, we now know by genetic influences." *Transcript,* page 327. He acknowledged that the spondylolisthesis[8] in the low back is a "mixed bag," meaning it's partly genetic and partly environmental. It is more common in people who are athletic and usually develops in childhood, not in adulthood as the result of trauma, according to Dr. Bernardi. *Id.* He informed that these conditions can cause low back and bilateral leg pain without specific trauma and that it is almost universally the case that regular activities of daily living can cause these conditions to become painful in the back and legs. Dr. Bernardi also acknowledged that employee's "history of never having had problems in his back before March the 9th, 2009, tends to suggest that his pain was not related to the slip in his back" and that "it tends to argue that the incident was the prevailing factor in causing his pain." Nevertheless, his conclusion was that the underlying condition causing the pain was not clearly identifiable from the objective evidence available. *Transcript,* page 329. Under those circumstances, he opined that the permanent disability resulting from the work injury, as opposed to other pre-existing conditions, was 2%.

Dr. Thomas Musich conducted an IME on behalf of the employee on June 5, 2013[9]. He found that the reported accident "is the prevailing factor in the development of acute symptomatic lumbar pathology and bilateral lower extremity radiculopathy" and that all the treatment to date was necessary due to the work injury. *Transcript,* page 78. Dr. Musich is Board Certified in Family Practice and as an Independent Medical Examiner. His practice areas are 75% devoted to independent medical evaluations. Dr. Musich found that employee suffered acute lumbar trauma resulting from the accident. He also found employee suffered from depression secondary to chronic low back pain. Dr. Musich reviewed the reports of the other doctors who

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[7] This was slightly altered from an earlier statement that the medication prescribed "for pain complaints would be half related to his work injury and half related to pre-existing degenerative changes." *Transcript,* page 179. This earlier statement was made prior to the doctor's review of additional medical records in which employee had sought medication for pain from other providers, after his last visit with Dr. Cantrell. *Transcript,* pages 174 – 176.

[8] According to Dr. Bernardi, spondylolisthesis is "a slippage of one bone relative to the bone under it," which can cause small stress fractures, as shown in employee's spine. *Transcript,* page 328.

[9] Employee was still in custody at that time until August 2013, according to the information provided in this record.

read the results of the objective testing, but he did not review those tests himself. *Transcript,* page 65. Even Dr. Musich acknowledged some of the identified abnormalities can be congenital and can cause spondylolisthesis, a slippage of one vertebra onto another.[10] *Transcript,* pages 56-57. Dr. Musich acknowledged that degenerative process usually does not occur acutely, "and it can take six months to years to develop prior to an abnormal finding on an X-ray." *Transcript,* page 65. Dr. Musich opined employee suffered a 65% disability of the man as a whole and he recommended the prior restrictions set by Dr. Coyle. He does not address the opinions of Dr. Cantrell regarding restrictions, although Dr. Coyle had referred employee to Cantrell, a physiatrist, to determine appropriate restrictions, after further testing and treatment. Dr. Musich further posited, "If vocational rehabilitation is unable to place Mr. Harris in an appropriate job setting, given all of the aforementioned conditions, then it is my medical opinion that Danny Harris is totally and permanently disabled solely due to the work trauma of March 9, 2009." *Transcript,* page 78. Dr. Musich never evaluated employee again after his examination in June 2013.

Employee was evaluated by two vocational rehabilitation specialists, who had differing opinions on whether employee was able to compete in the open labor market. Mr. Gary Weimholt is a certified disability management specialist hired by employee's attorney. Weimholt's evaluation was in July 2013, and he found employee to be totally vocationally disabled. He based his recommendation in part on the permanent restrictions placed by employee's doctors but it is unclear what he understood those to be, since he referenced the initial restrictions of Dr. Coyle at no lifting over 10 pounds at the onset, and contrasted them with the 50 pound limit set by Dr. Cantrell as a permanent restriction.[11] Weimholt appears confused as to when and at what restriction level employee returned to work. Weimholt included the restriction that employee needs to be able to recline at work, as suggested by Dr. Musich. No other doctor ordered that restriction at any point in time close to the work injury. Weimholt considered the fact that employee does not have a high school diploma and has not completed a G.E.D. or other advanced training. He also considered factors that are considered desirable by employers and found that employee's inability to use time wisely, maintain good work habits such as inability to get to work on time, etc. would further limit his employability.

Weimholt discounted the findings and impressions of the evaluator who performed a functional capacity evaluation (FCE) on June 29, 2009, before employee was returned to work. *Transcript,* page 234. Weimholt opined that the weight levels shown in the FCE were inappropriate levels for anyone to lift. *Transcript,* page 90. Weimholt appeared to rely on Dr. Musich's report, including his conclusory statements that employee suffers from depression due to the work injury. Weimholt did not have the advantage of the medical opinions of Dr. Bernardi in making his assessments.

The second rehabilitation expert was engaged by the employer in early 2016. Mr. James England, a certified rehabilitation counselor and Missouri licensed professional counselor, found employee was capable of competing in the open labor market, and identified several jobs based on employee's experience, transferrable skills, and his scores on various competencies. Mr. England noted through review of achievement test results, that employee had the apparent ability to complete the preparation and requirements for a G.E.D. diploma, but that he had not made any efforts in that regard since obtaining the paperwork to pursue this. It was Mr. England's opinion that employee had transferable knowledge that would be usable at a light level of exertion in service writing and dispatching, and at a medium level of exertion, with some additional training regarding general auto mechanics or truck driving and heavy equipment operations. Mr. England acknowledged Dr. Coyle's opinion that dump truck driving might not be

[10] Dr. Musich explained that a pars defect can be considered a spondylolysis which can be congenital and also is often seen with athletic injuries of gymnasts and football linemen, typically produced by bending backwards or with lumbar extension. *Transcript,* page 57.
[11] Dr. Coyle referred employee to Dr. Cantrell to determine workplace restrictions in 2010. *Transcript,* pages 155, 162.

a good idea. *Transcript,* pages 501 and 498. England also identified jobs within employee's capacities, such as cashier, security positions, courier, cab driver, and others. *Transcript,* page 462. He noted employee's restrictions imposed by Dr. Coyle - medium work activity with frequent positional changes about every hour; and Dr. Cantrell's weight limit of 50 pounds. Mr. England reviewed extensive medical records and reports, including those of Dr. Musich and Dr. Bernardi.

Employee has not returned to work since early-mid 2011, and has not found other employment.

Conclusions of Law
Accident.

Section 287.020.2 RSMo. defines "accident" as:

> [An] unexpected traumatic event or *unusual strain* identifiable by time and place of occurrence and *producing at the time objective symptoms* of an injury caused by a specific event during a single work shift. An injury is *not compensable because work was a triggering or precipitating factor.*

The March 9, 2009, work event was an unusual strain producing at the time objective symptoms of an injury during a single work shift. We so conclude based on all the circumstances – the medically documented onset of pain where previously there was none, the unusual circumstances of the work event involving heavy lifting, and certain conditions identified by the medical profession through testing, that can be attributed to trauma.

Medical Causation.

Section 287.020.3 RSMo. provides as follows:

> (1) ... An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. "**The prevailing factor**" is defined to be the primary factor in relation to any other factor, causing both the resulting medical condition and disability.

The administrative law judge cites *Weinbauer v. Grey Eagle*, 661 S.W. 2d 652, (Mo. App. 1983) to support his conclusion that: "An inherent weakness or bodily defect, such as spondylolisthesis, occurring in conjunction with an abnormal strain ... will support a claim for compensation." However, *Weinbauer* was decided prior to the change in the law finding that a condition is not compensable if work was merely a precipitating or triggering factor. § 287.020.2. We do not rely on *Weinbauer* as the administrative law judge reasoned.

Nevertheless, based on the opinions of the reviewing doctors, some of the symptoms experienced by employee resulted from the work accident. Even Dr. Robert Bernardi indicates that the accident of March 9, 2009 caused some level of permanent partial disability in the form of a chronic sprain or strain, or non-specific back pain. *Transcript,* page 334.

We conclude the work event on March 9, 2009 was the prevailing factor causing employee to suffer a chronic back sprain or strain.

However, employee has not proven that his work injury resulted in depression (or any psychological disability) for which he was briefly treated in 2011.

Nature and Extent of Permanent Disability.

Employee's current conditions are not entirely attributed to the effects of his work injury following lifting and flipping a backhoe tire on March 9, 2009. Dr. Musich, whom the administrative judge relied upon, appears to have found all of employee's symptoms could be attributed to his work injury. We disagree that the evidence supports this conclusion.

Early on, the objective evidence did not show an identifiable source of the radicular symptoms into the legs as complained of by the employee. The treating doctors did not identify clear evidence of acute injury. No doctor identified a specific condition from the imaging studies which could directly be traced to the work incident as the prevailing factor.

Where medical opinions are inconsistent or conflicting, objective medical findings are to prevail over subjective medical findings. § 287.190.6 RSMo. The objective diagnostic evidence confirms that as of March 2009, employee had several degenerative or congenital conditions present in his lumbar spine. Dr. Musich's opinion does not appear to acknowledge that these conditions had any effect on the current symptomology. Without giving due consideration to the objective medical findings, Dr. Musich opined that employee's disability related to the work injury was either 65% or permanent and total.[12]

The doctors we find most persuasive, Bernardi, Coyle, and Cantrell consistently conclude that the majority of employee's symptoms are from degenerative and congenital conditions, objectively identified through testing. Even Dr. Musich acknowledged that there is no way to know for sure if his pre-existing conditions impacted his current symptoms, without viewing imaging studies prior to the injury. No such studies exist for comparison purposes. However, it is known that degenerative conditions must be in existence months or years before they are observable on diagnostic images. Dr. Bernardi and Dr. Coyle, both neurosurgeons, opine that pre-existing conditions obvious on objective testing prompted much or all of employee's symptoms. We find the opinions of these doctors, having specialization in spinal injuries and conditions to be more persuasive than the broad-brush statements of Dr. Musich.

In contrast to Dr. Musich, Dr. Bernardi's opinion and diagnosis is consistent with the objective findings documented throughout the medical records. Dr. Bernardi, whose primary practice is in spinal surgery, found that employee had suffered at most, a strain or sprain injury, which he would have expected to resolve within weeks. He identified the degenerative processes which were clearly evident early on, as having a significant impact on the symptomology. Dr. Robert Bernardi opined that the permanent disability resulting from the work injury was 2%.

Dr. Cantrell rated employee's disability at 8% of the body as a whole referable to his lumbar and lower extremity complaints, finding that only one half of the disability was attributable to the work injury and the other half stemming from his pre-existing degenerative and congenital conditions.

The degree of disability is not strictly a medical question.[13] Employee has consistently maintained that he continues to have a level of pain affecting his ability to perform daily activities.[14] While we do not doubt that employee experiences pain, and that some of that pain is attributable to the injury to his back resulting from the accident, employee's reports of his pain level when measured against testing and observation by medical experts do not coincide with those findings. Dr. Cantrell, on June 8, 2011, noted that no radicular pain was evinced by standard leg raising tests and that his strength was normal in both lower extremities. *Transcript,*

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[12] Dr. Musich also presented the possibility of permanent and total disability if no appropriate work could be identified through a vocational rehabilitation process.

[13] *ABB Power T & D Co. v. Kempker*, 236 S.W. 3d 43, 52 (Mo. App. 2007)

[14] Because "there is no objective test for pain[,] the extent to which a claimant experiences pain is a credibility determination for the Commission to decide." *Ballard v. Woods Supermarkets,* 422 S.W. 3d 473, 478-79 (Mo. App. 2014)

page 178. Employee's report at the hearing was that his pain was getting worse. Employee's report of increasing pain, well after treatment had ended and MMI was found, is further support that his pain (at least in part) is derived from a degenerative or congenital condition. Employee's reports of continuing pain resulting from the work injury at an increased level beyond his last treatment examination are unsupported by any objective findings of acute injury at the time of the accident.

We find the level of permanent partial disability resulting from employee's work injury is 5% body as a whole referable to the low back.

The administrative law judge found employee to be permanently and totally disabled. We disagree that the evidence supports this conclusion. The only basis upon which the administrative law judge found permanent total disability was a conditional statement by Dr. Musich, which was dependent on the results of vocational rehabilitation efforts. The administrative law judge relied on Gary Weimholt's evaluation done in July 2013. Weimholt's analysis is based on his observations of the employee four years after the March 9, 2009 injury. Weimholt's evaluation was long after employee underwent a functional capacity evaluation on June 29, 2009, before being returned to work. That evaluation found him capable of returning to work with limitations. See *Transcript,* page 234[15] His evaluation was long after employee was found to be at maximum medical improvement in August 2009, and allowed to return to his same job; and well after employee had continued to work at the same job for two additional years (last working on March 25, 2011). It was well after employee had left that job for reasons that are not entirely related to his physical injury. Employee has not proven permanent total disability on the record before us.

In contrast, after Dr. Musich saw employee in June 2013, employee was also evaluated by Mr. James England in early 2016. After reviewing extensive records and interviewing employee, Mr. England found that employee was not incapable of competing in the open labor market. He was able to identify several areas of possible employment. We find Mr. England's vocational rehabilitation evaluation more persuasive.

Employer is not liable for any future medical treatment

As noted, no future medical treatment is authorized for psychological injury/disability because such was not proven to have resulted from the work accident.

No treating doctor has opined that employee needs additional medical treatment resulting from his back injury, as derived strictly from the back strain. We find credible, and adopt the findings of Dr. Bernardi, Dr. Wolfgram, and Dr. Cantrell, who opined the pain medications prescribed are either for treatment of degenerative conditions rather than any acute or chronic residual pain from the back strain or that they are not necessary or advisable. Dr. Musich did not prescribe or recommend medication. Employee has not met his burden of proof to show he is entitled to an order of future medical treatment. We conclude employer is not liable pursuant to § 287.140 RSMo to provide future medical treatment to cure and relieve the effects of the work injury.

Conclusion

We modify the award of the administrative law judge as to the issues of: (1) medical causation; (2) nature and extent of disability; and (3) future medical liability.

[15] It should also be noted that in making his assessment, Weimholt considered personal behavior factors which may be workplace competencies required by employers, such as managing time wisely, team skills, and maintaining good habits such as arriving at work on time. *Transcript,* page 140.

The award and decision of Administrative Law Judge Joseph E. Denigan, issued February 21, 2018, is attached hereto and incorporated herein to the extent not inconsistent with this decision and award.

The Commission approves and affirms the administrative law judge's allowance of an attorney's fee herein as being fair and reasonable.

Any past due compensation shall bear interest as provided by law.

Given at Jefferson City, State of Missouri, this 15th day of January 2019.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

Robert W. Cornejo, Chairman

Reid K. Forrester, Member

SEPARATE OPINION FILED
Curtis E. Chick, Jr., Member

Attest:

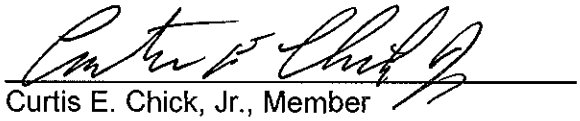
Secretary

SEPARATE OPINION
CONCURRING IN PART AND DISSENTING IN PART

The majority has voted to modify the Award of the administrative law judge on the issues of: (1) medical causation; (2) nature and extent of disability; and (3) future medical benefits. The majority has substituted its Findings of Fact and Conclusions of Law for those stated by the administrative law judge. I agree with the determinations adopted by the majority except as to the level of disability.

The majority modifies the nature and extent of disability, finding that a permanent partial disability at 5%, body as a whole referable to the low back has been proven, as opposed to the permanent total disability found by the administrative law judge. I agree that permanent total disability has not been proven. However, I would find a higher rating of permanent partial disability at the 10% level. I dissent in that respect.

I concur in the other aspects of the majority's modified award.



Curtis E. Chick, Jr., Member

Issued by DIVISION OF WORKERS' COMPENSATION

AWARD

Employee: Danny L. Harris

Dependents: N/A

Employer: Ralls County

Additional Party: Dismissed

Insurer: Missouri Association of Counties

Hearing Date: November 17, 2017

Injury No.: 09-018179

Before the
Division of Workers' Compensation
Department of Labor and Industrial Relations of Missouri
Jefferson City, Missouri

Checked by: JED

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes
2. Was the injury or occupational disease compensable under Chapter 287? Yes
3. Was there an accident or incident of occupational disease under the Law? Yes
4. Date of accident or onset of occupational disease: March 9, 2009 (stipulated)
5. State location where accident occurred or occupational disease was contracted: Ralls County
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? Yes
8. Did accident or occupational disease arise out of and in the course of the employment? Yes
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted: Employee sustained low back injury while manually lifting 350-pound tractor (backhoe) wheel assembly from the ground.
12. Did accident or occupational disease cause death? No Date of death? N/A
13. Part(s) of body injured by accident or occupational disease: low back
14. Nature and extent of any permanent disability: PTD from Employer
15. Compensation paid to-date for temporary disability: $4,586.29
16. Value necessary medical aid paid to date by employer/insurer? $51,464.55

17. Value necessary medical aid not furnished by employer/insurer? none

18. Employee's average weekly wages: $496.46

19. Weekly compensation rate: $330.97/$330.97

20. Method wages computation: Stipulation

COMPENSATION PAYABLE

21. Amount of compensation payable:

Permanent total disability benefits from Employer beginning August 31, 2009 for Claimant's lifetime	indeterminate

22. Second Injury Fund liability: None

TOTAL: INDETERMINATE

23. Future requirements awarded: Yes (see narrative Award)

Said payments to begin immediately and to be payable and be subject to modification and review as provided by law.

The compensation awarded to the claimant shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorneys for necessary legal services rendered to the claimant:

Noel Sevastianos
Mark Haywood

FINDINGS OF FACT and RULINGS OF LAW:

Employee:	Danny L. Harris	Injury No.: 09-018179
Dependents:	N/A	Before the Division of Workers' Compensation Department of Labor and Industrial Relations of Missouri Jefferson City, Missouri
Employer:	Ralls County	
Additional Party:	Dismissed	
Insurer:	Missouri Association of Counties	
Hearing Date:	November 17, 2017	Checked by: JED

This case involves a compensable low back injury resulting to Claimant on the reported accident date of March 9, 2009. Employer/Insurer admits Claimant was employed on that date and that any liability is fully insured. The Second Injury Fund is not a party to the claim. Both parties are represented by counsel. Claimant alleges permanent total disability.

Issues for Trial

1. Whether injury arose out of and in the course of employment;
2. Medical causation/attribution;
3. liability for future medical treatment; and
4. nature and extent of permanent injury.

FINDINGS OF FACT

Treatment

FIRST VISIT

The records of Dr. James Coyle, treating surgeon, were offered as Exhibit C. Dr. Coyle first examined Claimant on March 23, 2009. He presented, age 30, with complaints of low back pain and right lower extremity pain. He gave a work-related patient history of injury while changing tires on a backhoe tractor.

Dr. Coyle noted Claimant's past medical history was unremarkable and surgical history significant for knee surgery.

On physical examination that date, notes included Claimant's 6'4", 270 pound build. Claimant had tenderness only in his right paralumbar muscles and tenderness over the right SI joint, radiating pain was noted in his right buttock and right posterior thigh, he forward flexed to 80 degrees, SLR was negative, reflexes were even bilaterally and he had no weakness or pain with hip rotation.

Review that date of Claimant's March 16, 2009 MRI was remarkable for central disc protrusions at L4-5 and L5-S1. He noted bilateral L5 spondylolithesis.
His IMPRRESSION was "Lumbar disc herniations."

The doctor's OFFICE VISIT REPORT Form of March 24, 2009 reflected a 10 pound lifting restriction and no driving, among other restrictions, signed by Dr. Coyle.

SUBSEQUENT VISITS

One month later, the OFFICE VISIT REPORT Form of April 20, 2009 reflected the same 10 pound lifting restriction. Although not contained in the Exhibit, the note of May 20 recounted the separate physical examination notes of April 20, 2009:

> ... he was noted to have back pain, right sided buttock and posterior thigh pain, and dysesthesia radiating into his right foot.[1]

Dr. Coyle further noted a history of three injections without relief. Physical examination notes of May 20 reflect forward flexion to 60 degrees with pain, tenderness to palpation over the L5 spinous process, dysesthesia into the anterior thighs and lateral calves, diffuse tingling in both feet and no appreciable motor deficits. He recommended pain management and a rehabilitation program, including aquatic physical therapy if possible. Dr. Coyle noted Claimant was unable to work and that he advised surgery was a last resort if conservative measures fail.

Claimant was in significant pain and prognosis was discussed. With a lack of response to injection therapy, Dr. Coyle gave a very guarded prognosis from any surgery. His age of 30 and a "two level fusion" would not return him to pre-injury state.

Additional treatment notes found in this Exhibit resume about one year later in August 2010. On August 25, 2010, Dr. Coyle recounts that , "He injured his low back March 9, 2009, changing a tire on a backhoe." On that date, Dr. Coyle ordered a second EMG to compare with the earlier test "... and see if there is any possibility that we can help him with a one-level anterior interbody arthrodesis alone."

On September 27, 2010 Dr. Coyle reports:

> His EMG was remarkable for abnormalities of fibrillations and polyphasic motor unit potentials in the left gastrocnemius and polyphasic motor unit potentials in the right gastocnemius, both of which are supplied by the S1 nerve root.[2]

He noted no radiculopathy at L4 or L5. He ordered another MRI.

The MRI Report, by Dr. David Niebruegge, of October 27, 2010 was notable for mild dessication at L4 and L5 with annular tears at each level, L4-L5 as generalized bulging with focal

[1] This omission is unexplained in the record or in the proponent's brief.
[2] The second EMG/NCS report prepared by Dr. Cantrell's corroborates Dr. Coyle's summary. (See Exhibit E, note of September 15, 2010.)

central and right paracentral disc protrusion with the same finding at L5-S1, with the addition of an annular tear. No focal compressive pathology was appreciated.

Dr. Coyle's physical examination that date included bilateral radicular pain and "numbness in the L5 distribution on his feet." Dr Coyle explained surgical alternatives to Claimant with the conclusion that "there is really no good surgical option for him." He believed current employment as a dump truck driver was a "mismatch."

* * *

On August 25, 2010, Dr. Coyle writes, "When I saw [Claimant] in August 2009, I recommended avoiding surgery if at all possible. [...] At this point I still have the same reservations I had a year ago."

As late as October 27, 2010 Dr. Coyle writes, His EMG showed an S1 radiculaopathy. I recommended he avoid surgery if at all possible. [...] I have advised Mr. Harris that there is really no good surgical option for him."

In a letter to Dr. Coyle dated November 15, 2010 (Exhibit E), Dr. Russell Cantrell, physiatrist, indicates his plan to continue to see Claimant every six months, despite having attained MMI, in order to maintain his current medications. Follow up was schedule for May 16, 2011.[3]

EMG STUDIES TO DETERMINE
ELECTRODIAGNOSTIC EVIDENCE OF RADICULOPATHY
Recapitulation

First Study:	June 6, 2009 Dr. Boris Khariton (Exhibit H) Normal Study. No electrodiagnostic evidence of lumbar radiculopathy.
Second Study:	<u>September 15, 2010</u> - Dr. Russell Cantrell writes (Exhibit E): Needle EMG of the representative muscles in both lower extremitites was remarkable for abnormalities of fibrillations and polyphasic motor unit potentials in the left gastronemius and polyphasic motor unit potentials in the right gastronemius, both of which are supplied by the S1 nerve root. I found no EMG evidence of radiculopathy at the L4 or L5 level. <u>September 27, 2010</u> - Dr. Coyle writes (Exhibit C): ... he underwent an EMG nerve conduction study by Dr. Russell Cantrell. His EMG was remarkable for abnormalities of fibrillations and polyphasic motor unit potentials in the left gastrocnemius and polyphasic motor unit potentials in the right gastocnemius, both of which are supplied by the S1 nerve root. October 27, 2010 Dr. Coyle: "His EMG showed an S1 radiculopathy."

[3] This letter is not found in Exhibit C.

> June 17, 2011 (nine months later) - Dr. Cantrell writes (Exhibit E): Mr. Harris underwent electrodiagnostic studies which revealed findings felt to be consistent with chronic bilateral S1 radiculopathy in the abse nce of any l4 or L5 denervation and the absence of any peripheral polyneuropathy. These electrodiagnostic studies had been requested by Dr. Coyle as a results of radiating pain in his left greater than right lower extremity in conjunction with ongoing lumbar back pain. I had made note at that time that Mr. Harris had previously undergone electrodiagnostic studies on June 6, 2009 by Dr. Boris Khariton [...]. (Underline added.)
>
> November 11, 2015 - Dr. Bernardi writes (Exhibit. K; *Dep. Ex. 2*): On the EMG , polyphasic motor unit potentials were present in both gastrocnemii suggestive of chronic S1 radiculopathy. (Underline added.) (Not a treatment record.)

(At deposition, Dr. Bernardi acknowledged the EMG was positive for bilateral radiculopathy from the S1 nerve root (pp. 40-41). There was no discussion of the characterization as *chronic* injected into the record by Dr. Cantrell on June 17, 2011 and then repeated in Dr. Bernardi's narrative report as part of his medical records foundation.)

On May 27, 2009, Dr. Cantrell writes, "[upon review of the March 16, 2009 MRI], which in my opinion reveals degenerative disk disease ... and a more central and paracentral disk protrusion at the L5 S1 level which appears to result in some compression of the descending S1 nerve root. [...] Mr. Harris presents at this time with complaints that are suggestive of right L5 radiculopathy." (Underline added.) (Exhibit E.)

Dr. Cantrell ultimately assigned an eight percent PPD rating explaining half of which was attributable to *pre-existing* degenerative and congenital "abnormalities." Dr. Cantrell diagnosed discogenic and neuropathic pain.

Medical Opinion Evidence

Dr. Musich

Claimant offered the deposition of Thomas Musich, D.O. as Exhibit 1. Dr. Musich reviewed the medical record and took a patient history, parallel to that given Dr. Coyle, of changing the tire on a backhoe tractor. Dr. Musich provided the additional explication of the "rim complex" of the tractor wheel, its 350-pound weight, and Claimant's task of handling it manually, i.e. flipping it, in order to change the tire. He noted no prior low back injury, disabling pain or radiculopathy. Current complaints included constant low back pain and bilateral radicular pain, left greater than right. Claimant relayed bilateral symptoms of plantar paresthesias aggravated by valsalva activity and prolonged positioning.

Dr. Musich's physical examination notes included forward flexion to 40 degrees, extension to 10 degrees, and lateral flexion to 18 degrees bilaterally, all accompanied by pain. Dysesthia noted in the L4 and L5 dermatomal patterns of both feet, bilateral great toe weakness and initial gait antalgic. Dr. Musich's diagnoses parallel the orthopedic record. He found the reported accident to be the prevailing factor in causing Claimant's acute symptomatic lumbar pathology and bilateral lower extremity radiculopathy and the need for treatment. Dr. Musich's notes and testimony embrace the treatment record and observations of Dr. Coyle, the treating orthopedic surgeon.

Similarly, Dr. Musich found the reported accident is the prevailing factor underlying Claimant's persistent and ongoing low back pain and radiculopathy. He found Claimant sustained a sixty-five percent permanent partial disability of the body referable to the reported injury. He further embraced the restrictions imposed by the treating orthopedist and home exercise. Dr. Musich recommended vocational rehabilitation, which, if unsuccessful, would render Claimant permanently and totally disabled due to the reported injury.

Dr. Bernardi

Employer offered the narrative report and deposition of Dr. Robert Bernardi, neurosurgeon, as Exhibit K. Dr. Bernardi reviewed the medical record and examined Claimant. He noted the accident mechanism for the reported injury as "bent forward at the waist to flip over a large tire." He testified similarly (p. 13). Dr. Bernardi's report is separated into categories. Two pages address context, patient history and brief physical examination. He detailed more than five pages of treatment records, including details of Claimant's personal life.

Dr. Bernardi's records reviews are inaccurate at important points regarding clinical evidence of radiculopathy. First, Dr. Bernardi's summary of Dr. Coyle's May 20, 2009 notes does not include Dr. Coyle's positive findings of dysesthesias into the anterior thighs and calves plus diffuse tingling in both feet.

Second, in his records review, he describe the results of the September 2010 EMG as:

> On the EMG, polyphasic motor unit potentials were present in both gastronecmii suggestive of *chronic* S1 radiculopathy. (Italics added.)

At deposition, Dr. Bernardi stated his diagnoses of backache, congenital stenosis, degenerative disc disease and spondylolithesis indicating all but the backache were pre-existing conditions to the reported accident. It is noteworthy that he characterizes the spondylolisthesis as a "mixed bag" and says "people who are athletes" develop it and, at the same time, states it is developed in childhood (p. 14-15). He refers to a slippage and that, although a "sticky wicket," "I can say that it tends to argue that the incident was the prevailing factor in causing his pain." He said it is accompanied by "waxing and waning episodes of low back pain." When asked about the underlying condition he stated, "I don't know, I'm not sure what the underlying condition is that's causing this man's pain, I don't have a good explanation for it." (p. 16.) He stated twice that he found no symptom magnification (p. 17-18). He stated the radiographic studies did not

show any acute injury. Dr. Bernardi stated the degenerative disc disease "is a wear and tear aging process." He said Claimant symptoms, including leg pain, should have resolved in four to six weeks. He had no medical explanation for Claimant's "chronic discomfort." (p. 20.)

Dr. Bernardi said the reported accident was not the prevailing factor in causing any of the conditions he diagnosed but thought the reported accident caused two percent permanent partial disability. He found Claimant to have attained maximum medical improvement and did not believe Claimant required any restrictions or further treatment. He stated personal improvements of weight loss and quitting smoking were important and that Claimant would benefit from OTC anti-inflammatory medication. He thought Claimant could return to work. He did not believe the reported accident caused any change in the underlying pathology of his back. (pp. 19, 25)

On cross-examination, Dr. Bernardi agreed he would "just disagree" with Dr. Coyle's notation of radicular symptoms (p. 33). When asked if he discussed those findings with any of Employer's treating physicians he stated, "A grand total of zero." Subsequently, Dr. Bernardi acknowledged Dr. Hevel's note of radiating pain just two days post-accident but sought to distinguish whether that demonstrated actual "radicular" pain. He said several things can cause radicular pain besides a "pinched nerve" but, did not have an opinion as to what caused Claimant's leg pain. (p. 34-35)

In response to questions about other treatment decisions for Claimant's work injury, Dr. Bernardi stated that it was debatable whether the pain was from a work injury. He further stated, "You can't see anything on this gentleman's imaging studies or find anything on his exams that correlates with his exams (sic); so the injury itself remains undefined." (p. 36) He admitted the slippage with spondylolithesis produces numbness and tingling in the thighs, calves and feet as reported by Claimant and noted by Dr. Coyle and Dr. Cantrell. (pp. 37-38.) He seemed unaware of the (severe) 10-pound lifting restriction imposed as of June 17, 2009 imposed by Dr. Cantrell. (p. 39.) Dr. Bernardi admitted that the AMA Guidelines characterize complaints of chronic pain as permanent injury. (p. 78.)

Dr. Wolfgram

Employer also offered the deposition of Dr. Edwin Wolfgram, psychiatrist, as Exhibit M. Dr. Wolfgram reviewed the record and interviewed Claimant. He noted Claimant's work history and current unemployment. Dr. Wolfgram noted personal legal problems, including divorce, and asserted multiple addictions (disputed by Claimant at trial). Dr. Wolfgram referenced a driving while intoxicated charge which was disputed by Claimant and unproven by other evidence. Dr. Wolfgram concluded Claimant has an addictive personality. He diagnosed depression.

Dr. Wolfgram's opinions far exceed the notes and "single episode depression, post-lumbar injury, made by Dr. Jonathan Colen in conjunction with Claimant primary physician, Dr. Robert Hevel. Dr. Wolfgram attributes Claimant's depression to personal behaviors. Contrary to Employer's treating physician, he believes Claimant needs to stop using prescription analgesics.

Vocational Opinion

Mr. Weimholt

Claimant offered the narrative report and deposition of Mr. Gary Weimholt, LRC, as Exhibit 2. Mr. Weimholt reviewed the medical record and interviewed Claimant. He took a detailed employment history that consisted of heavy manual labor and trucks and equipment operation. He noted the early MRI and referral to a surgeon, Dr. Coyle. Dr. Coyle made the stated diagnoses and imposed restrictions expressly noted by Mr. Weimholt:

> ...no lifting over 10 pounds, no repetitive bending, stooping or twisting as the waist and intermittent sit, stand and walk. He also recommended he not drive dump trucks or pick-up trucks.

On July 29, 2009, Dr. Cantrell imposed:

> ...permanent restrictions of no lifting over 50 pounds and alternating sitting and standing on every hour.

(Exhibt 2; Deposition Exhibit 2, p. 6.) Mr. Weimholt expressly notes he was unaware of any medical records of low back treatment or diagnoses *pre-existing* the reported injury. Dr. Cantrell saw Claimant thereafter, placing Claimant at MMI on November 15, 2010, further noting Claimant's ongoing use of Tramadol to control pain. Subsequent Functional Capacity Examination was reported to have positive Waddell's Sign and pain magnification. This was considered clinically insignificant given the lumbar diagnoses and communications issues between Claimant and the administrator.

Mr. Weimholt also contemplated a diagnosis of single episode depression, per Dr. Jonathan Colen, manifesting about six months following the reported injury. He referenced a GAF of 65. Mr. Weimholt noted Claimant completed 9th grade without attainment of a GED. He administered testing to Claimant and prepared a jobs survey.

Mr. Weimholt concluded Claimant had no transferable skills and that he would need assistance in completing a GED. Claimant has no administrative support experience or keyboard skills. He does not use email. Mr. Weimholt understood ongoing restrictions would include no regular lifting and the ability to alternate sitting and standing on an hourly basis. Dr. Musich thought Claimant would require the ability to recline as needed. On this basis, he found Claimant was without access to the open labor market and totally vocationally disabled from employment. He opined that even with training, his limitations and restrictions foreclosed employment.

Mr. England

Employer offered the narrative report and deposition of James England, LRC, as Exhibit L. Mr. England reviewed the medical record and Mr. Weimholt's tests. He interviewed Claimant. He understood Claimant took Tramodol for lower extremity pain and that Claimant had no upper body problems. He understood Claimant can stand for 45 minutes and walk 2-3

blocks at a time. He understood Dr. Cantrell imposed a 50-pound lifting restriction and an hourly sit/stand alternate while at work. He was aware that Dr. Musich thought Claimant should adhere to Dr. Coyle's original severe restrictions. Mr. England summarized the heavy lifts recorded at the FCE without comment on Claimant tall stature and heavy weight. He thought he could pass a GED with preparation. He agreed Dr. Bernardi's opinions were inconsistent with the other doctors' findings (p.48-49).

Mr. England believed Claimant had transferable skills for service writing for general mechanics and equipment operation. He said, "medium range of exertion as long as he could change positions every hour." This opinion was not developed with regard to available employers and full-time endurance in either the narrative report or at deposition. Mr. England juxtaposed Dr. Bernardi's findings and absence of any work restrictions, which would require no vocational rehabilitation, with the findings "of the other doctors," in which case job placement services would be available to him through the state agency. Mr. England did not discuss Dr. Bernardi's admissions against interest nor his inability to explain Claimant's pain condition.

RULINGS OF LAW

Injury and Medical Causation

Claimant presented cogent medical records evidence from a qualified surgeon and a host of other treating physicians that document the onset of disabling symptoms as the result of the reported injury. Acute symptoms warranted MRI within week of the reported accident. Claimant credibly testified that he never had low back injury or treatment prior to the reported accident date. Employer offered no evidence of absenteeism, low back problems, accommodations or other evidence of pre-existing disabling symptoms. Claimant's testimony was credible and unrebutted.

Dr. Coyle's initial diagnosis of lumbar disc herniations with history of work related accident was and remains consistent with the treatment record and Claimant's patient history. Radicular complaints evidencing active disc pathology were corroborated as late as the September 2010 by the EMG report of positive findings for radicular pain complaints served by the S1 nerve root. Dr. Coyle twice discussed surgery with claimant with the ultimate conclusion that the additional lumbar pathology of spndylolithesis simply did not make surgery a good option. The undisputed evidence is that he took breaks in the lounge, and got out of his truck as needed when he returned to work during the remainder of 2009 and 2010 (after treatment with Dr. Coyle terminated). He remained medicated. Dr. Musich opinions paralleled Dr. Coyle's treatment plan, diagnoses and restrictions. He reiterated Dr. Coyle's initial severe restrictions of no lifting over 10 pounds, etc.

Both his family doctor and his psychiatrist diagnosed depression secondary to the reported injury with no mention of prior depression. Claimant had no prior low back injuries or treatment.

A comparison of the treatment record with Dr. Bernardi's 2015 summary of that record reveals two apparent misunderstandings that weaken the foundation of his opinion testimony.

First, Dr. Bernardi seems to lack an understanding of the facts of the reported injury. The only words used in his entire report were, as stated above, "bent forward at the waist to flip over a large tire." The undisputed facts, unchallenged on Claimant's cross-examination, was that Claimant was changing a tire on a backhoe tractor, and lifted the tire and rim assembly alone. At an estimated weight of 350 pounds, the wheel size was the enormous tire on the rear axle of the tractor. Claimant explained he had to handle the wheel to prepare the rim complex. At trial, Claimant testified the wheel was lifted half way up, when he felt pain in his low back and legs. This change of tire occurred in the field without benefit of hoists, or other equipment. These details raise make inescapable the question of whether a man without Claimant's physical stature would attempt to undertake this task.

Thus, there is reason to believe Dr. Bernardi did not realize the physical demands inherent in this activity and was, fairly, misinformed from the outset. Thereafter, he seeks to persuade of his probabilities-based opinions which are not traceable to the facts of Claimant's undisputed accident history and treatment records.

Second, Dr. Bernardi summarized the results of the September 2010 EMG as *chronic*, which characterization is not discernible from a review of either the actual EMG report or Dr. Coyle's notes, yet is presented in his report, in list format, as though a summary of the actual words of the test and its interpretation. His (detailed) summary of Claimant medical record does not contain the contemporaneous EMG readings understood by both the test administrator, Dr. Cantrell, and the treating surgeon, Dr. Coyle. This characterization misleads the reader on a fundamental fact determination undertaken by Claimant's physicians in 2010 and, secondarily, by this tribunal. The mischaracterization serves to suggest Claimant's radicuplopathy was chronic, or pre-existing. There is no evidence in this record of any pre-existing problems of low back pain or radicular complaints.

In fact, the only source of this language, i.e. *chronic*, is Dr. Cantrell's *final report* dated June 17, 2011, quoted above. While Dr. Cantrell was treating physician, this report (four pages) does not enunciate a treatment visit but rather discusses records review and final medical disposition of Claimant's case.

Dr. Benardi posits that disc bulges and herniations are usually asymptomatic but does not reconcile this notion with the undisputed evidence of injury with disabling symptoms, as recorded and commented upon by a recognized spine surgeon. Moreover, the reported accident mechanism is not a routine lift or minor event but, rather, the lifting of an enormous wheel and tire assembly in the field without assistance and, again, is not reconciled by Dr. Bernardi's general thoughts about lumbar disc pathology and incidence in the general population. Still further, Dr. Coyle's thoughts are corroborated by the balance of the treatment record and Claimant's consistent patient histories.

While the failure to reconcile the unusual strain (i.e. 350 pound lift), the absence of prior low back treatment and Dr. Coyle's unequivocal findings of post-accident onset of disabling low back symptoms (with corroboration by the family doctor, ESI doctor, and EMG/NCS doctor) with his own opinions is the primary basis for giving less weight to Dr. Bernardi's opinions, other minor defects render his report less reliable. His subordination of the accident mechanism to "flip over a large tire," overlooking Dr.Cantrell's contemporaneous corroboration of S1

distribution of Claimant's complaints, and his gratuitous detail of Claimant's domestic legal problems are inexplicable. Finally, on the last page of his report, his generic lament, in series, that he is unable to "identify" medical bases for Claimant's complaints, Claimant's restrictions or Claimant's unemployment simply returns the reader to question why he has no criticism of Dr. Coyle, and the several physicians corroborating him in his assessment and management Claimant's post accident symptoms. [4]

On the other hand, Dr. Musich, who embraced the undisputed notes and diagnoses of the treating surgeon, offers additional insight into this case. Dr. Musich gains additional credibility from his 2014 hindsight and as a 35-year general practitioner who historically help manages similarly-situated patients by monitoring treatment and prognosis by spine specialty providers (i.e. surgeons, radiologist, neurologists, physical therapists, etc). Having embraced the opinions of Dr. Coyle, Dr. Musich is found to be more convincing than Dr. Bernardi, or Dr. Cantrell, regarding causation and permanent disability.

Dr. Bernardi seems to confuse the concepts of pre-existing pathology with pre-existing disability. The court in Weinbauer v. Grey Eagle, 661 S.W.2d 652, 654 (Mo.App. 1983), discusses the event of a work related accident escalating a pre-existing condition to a disabling condition. "An inherent weakness or bodily defect, such as a spondylolithesis, occurring in conjunction with an abnormal strain, such as Claimant suffered here will support a claim for compensation." Id. [Citations omitted.]

The record contains no evidence of prior injury or treatment of low back pain or leg pain. Disabling symptoms were documented and treated by numerous qualified physicians. Here, Dr. Musich is more persuasive than Dr. Bernardi for a number of reasons, most important is that his opinions are traceable to the objective findings in the treatment records and tests and were consistent with Claimant's credible testimony. Dr. Bernardi's admissions against interest and unsupported denials further weakened his opinions. His probability-based arguments and his inability to distinguish pre-existing asymptomatic anatomic defect and active, disabling pathology was addressed by the courts in Weinbauer. This evidence compels a finding that the reported accident is the prevailing factor in causing Claimant's disabling symptoms and need for treatment. The parties stipulated Claimant attained MMI on August 31, 2009.

[4] Drs. Cantrell and Bernardi seemed willing to speculate on Claimant's perception of pain but less willing to analyze Claimant's accident history and physical stature. Claimant's employment history of unaccommodated heavy labor and propensity to undertake heavy tasks is consistent with his accident history and his FCE performance. At 6'4" and 285 pounds, lifting 75 pounds may be perceived as unencumbered, or pain free, ability to work. Each emphasized Claimant's purported symptom magnification by the medical technician (Exhibit I). However, no treating physician, other than Dr. Cantrell, made any note of symptom magnification or the necessity to lift 75 pound to chest and overhead. There is no reason to think Claimant hesitated to do this any more than he thought about lifting a 350-pound wheel assembly, other than compliance with the directive. With regard to lifting 75 pounds, or more, during the FCE, it is unclear why this was deemed appropriate (regardless of causation) in a person with such severe lumbar diagnoses. This becomes particularly poignant when Employer's own physicians had imposed a 50-pound lifting restriction.

Nature and Extent of Permanent Disability

Claimant presented substantial evidence of ongoing disabling pain and limitations. Claimant credibly testified that his pain and limitations continue to the same degree as compared to those presented to Dr. Musich during his evaluation. Dr. Musich assigned a severe PPD percentage of sixty-five subject to the findings of a vocational rehabilitation specialist. Mr. Weimholt found Claimant was totally vocationally disabled from employment. He based this on Claimant's lack of transferable skills and his physical limitations. Depression was not primary in his analysis.

Dr. Cantrell assigned an eight percent PPD rating explaining half of which was attributable to *pre-existing* degenerative and congenital "abnormalities." (Exhibit E.) Under Chapter 287, a percentage of "permanent partial disability" may be assigned for permanent "disability," not abnormalities. Section 287.190.6(1) RSMo (2000). Dr. Cantrell's PPD percentage is supplanted by his own work restrictions. Dr. Bernardi assigned a two percent PPD.

Here, in conjunction with the well-reasoned opinions of Mr. Weimholt, this record of evidence compels a finding that Claimant is permanently and totally disabled as a result of the reported injury.

Future Medical Treatment

A claimant is entitled to future medical treatment if he shows by reasonable probability that the future medical treatment is needed to "cure and relieve....the effects of the injury." Section 287.140.1, RSMo. 2005; Concepcion v. Lear Corporation, 173 S.W.3d 368, 372 (Mo. App. 2005). A claimant is not required to show "conclusive" testimony or evidence to support a claim for future medical benefits; it is sufficient if the evidence shows by "reasonable probability" that he is in need of additional medical treatment by reason of the work-related accident. Landers v. Chrysler Corp., 963 S.W.2d 275, 283 (Mo.App. 1997). In Dean v. St. Luke's Hospital, 936 S.W.2d 601 (Mo.App. 1997), the court held that the standard for proof of entitlement to an allowance of future medical treatment is the claimants must show by "reasonable probability" that they will need future medical treatment.

In Mathia v. Contract Freighters, 929 S.W.2d 271, 277 (Mo.App. 1996), the court stated:

> The right to obtain future medical treatment should not be denied merely because it has not yet been prescribed or recommended as of the date of a workers' compensation hearing, regardless of whether there is evidence that its future need will be reasonably probable. Likewise, such future care to "relieve" should not be denied simply because a claimant may have achieved maximum medical improvement, a finding not inconsistent with the need for future medical treatment.

The type of treatment authorized can be for relief from the effects of the injury even if the condition is not expected to improve. Landman v. Ice Cream Specialties, Inc., 107 S.W.3d 240, 248 (Mo. banc 2003). Here, the severe injury and ongoing medication bespeak the proof of

Claimant's entitlement to future medical benefits. Dr. Musich, and to a lesser extent Dr. Cantrell's plan to follow Claimant's medication, each credibly endorse Claimant's need for ongoing treatment.

Conclusion

Accordingly, on the basis of the substantial and competent evidence contained within the whole record, Claimant is found to have sustained permanent total disability as a result of the reported injury and, heginning August 31, 2009, is entitled to benefits for the remainder of his life, or until he is no longer permanently and totally disabled. Claimant is entitled to future medical benefits to cure and relieve the effects of the injury.

I certify that on 2-2-18, I delivered a copy of the foregoing award to the parties to the case. A complete record of the method of delivery and date of service upon each party is retained with the executed award in the Division's case file.

By _____

DIVISION OF WORKERS' COMPENSATION
DEPARTMENT OF LABOR
INDUSTRIAL RELATIONS

Made by: _____
JOSEPH E. DENIGAN
Administrative Law Judge